FLORIDA STATE UNIVERSITY
OFFICE OF HUMAN RESOURCES
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ACCIDENT INVESTIGATION REPORT

Instructions:
The supervisor must complete and submit this investigation form to the Workers' Compensation Manager in the Office of Human Resources within two (2) workdays following a work-related injury/accident. Please investigate and thoroughly answer all of the questions, including the actions taken to prevent a recurrence. Send completed forms via email to hr-workerscomp@fsu.edu. If you have any questions or concerns, feel free to contact our office for assistance.

Accident Information

Date of accident | Time of accident ☐am pm☐ | Location of accident

Name of injured | Position title | Length of experience on job Year(s) Month(s)

Name of witness | Name of witness | Name of witness

Describe the accident and how it occurred

Cause of the accident

Was personal protective equipment required? ☐ Yes ☐ No

Was personal protective equipment provided? ☐ Yes ☐ No

Was personal protective equipment used? ☐ Yes ☐ No

If not used, explain:

Was safety training provided to the injured? ☐ Yes ☐ No

Interim actions taken to prevent recurrence:

Permanent actions taken to prevent recurrence:

Acknowledgement
The accident investigation conclusions have been reviewed and discussed based on the existing facts, and recommendations for corrective action have been implemented. To my knowledge, the information here is accurate and complete.

Employee signature | Date | Supervisor signature | Date

Dean/Director signature | Date